STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085013	A. BUILDING _____ B. WING _____	C 06/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE CENTER	810 SOUTH BROOM STREET WILMINGTON, DE 19805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual and complaint survey was conducted at this facility from May 31, 2012 and concluded on June 12, 2012. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility and hospital documentation as indicated. The facility census the first day of the survey was 99. The survey stage 2 sample totaled 56 residents with 5 closed records.	F 000		
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another	F 164	Privacy and Confidentiality continue to be maintained/protected for residents in the center. Licensed Nursing staff will be re-educated on or before 7/5/12 on protecting privacy and confidentiality of clinical records and personal information to include but not limited to leaving personal information visible on top of the medication carts. Random audits will be completed by the Assistant Director of Nursing will be done daily for the first 30 days and then monthly for 2 months by the DON/designee to determine that the nurses are following the policy for providing privacy and confidentiality . The Assistant Director of Nursing shall report to the Administrator and QA Committee monthly any variances in the data collected. The QA Committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance	7/5/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jane Quark — TITLE: Administrator — (X6) DATE: 6/28/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure the privacy and confidentiality of personal and clinical records and/or personal medical information for 17 (R1, R31, R33, R38, R48, R76, R77, R94, R95, R100, R114, R117, R133, R140, R142, R165, and R171) out of 56 Stage 2 sampled residents. Findings include: 1. Observation on 6/1/12 at 8:05AM revealed an unattended medication cart on the second floor North Hall. On the top of the cart was the MAR (Medication Administration Record) which was open to R94's medication page that was visible to anyone in the hallway. Additionally, on the top of the medication cart laying face up, was a "nurse's sheet " that contained R94's personal medical information such as laboratory results, code status, wounds, Foley catheter and bowel movements. 2. Observations on 6/1/12 and 6/4/12 revealed that on top of the medication cart, laying face up within view of anyone in the hallway, was a "nurse's sheet" that contained R133's personal medical information such as laboratory results, code status, wounds, Foley catheter and bowel movements. Additionally, observation on 6/4/12 revealed an unattended medication cart on the second floor North Hall, on top of which was the MAR open to R133's medication page that was within view of anyone in the hallway.	F 164		

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F 164	Continued From page 2 3. Observations on 6/1/12 and 6/4/12 revealed an unattended medication cart on the second floor North hall. The medication cart had laying on top of it, face up, a "nurse's sheet" which contained personal medical information for an additional 15 residents (R1, R31, R33, R38, R48, R76, R77, R95, R100, R114, R117, R140, R142, R165, and R171. This "nurse's sheet" containing medical information was visible to anyone in the hallway. Findings were confirmed with E10 (nurse) on 6/1/12 and E11 (nurse) on 6/4/12.	F 164		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based upon observation and interview, it was determined that the facility failed to promote care for three (R11, R107 and R56) out of 56 Stage 2 sampled residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his individuality. Findings include: Observation on 5/31/12 in the 4th floor dining room during lunch revealed that the food steam table arrived on the floor at 12:35PM. All of the residents in the dining room were served, except for R11, R107 and R56. The staff proceeded to serve the residents on the North hall and then the	F 241	Residents identified continue to receive their meals in a timely mannerr along with others in the dining room. Current residents are being monitored for prompt service. In-servicing was completed for dietary staff on dining room service on June 26, 2012. Daily audits shall be completed times 30 days then monthly for 60 days. This shall be the responsibility of the Food Service Director/designee. The Food Service Director shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	7/5/12

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F 241	Continued From page 3 South hall in their rooms. This took 30 minutes. The dietary staff then returned to serve R11, R107 and R56 in the dining room. During an interview with R11 on 5/31/12, who was sitting at a table by herself, she stated, "I am hungry and I am a diabetic. I need to eat". R11 was not served her meal until 1:00 PM. R11 did not need assistance with her meal. In an interview with R107 on 5/31/12, who was sitting at a table by herself, she stated, "I am waiting on a sandwich". R107 was not served her meal until 1:03 PM. R107 did not need assistance with her meal. Observation on 5/31/12 of R56 revealed that she was sitting in the dining room at a table with three other residents. These three residents did not need assistance with their meal and were served their lunch at 12:35 PM. R56 sat there for 30 minutes with these three resident's while they were eating until a staff member came to sit with her and assist her with her meal. Findings were confirmed with E1 (Administrator) on 6/11/12.	F 241		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was	F 253		

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F 253	Continued From page 4 determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Findings include: 1. Observations made during a facility tour with E15 (Maintenance Director) on 6/1/12 revealed stained ceiling tiles in resident rooms: 204, 304, 327 and 329. 2. On 6/1/12, plugged sinks were observed in resident rooms 302, 328 and 402. E15 confirmed this finding. 3. On 6/1/12, the caulking around hand sinks in resident rooms 301 and 328 were observed in disrepair. E15 confirmed this finding. 4. On 6/1/12, bathroom trash cans and/or plastic bags inside the trash can were observed missing in resident rooms 202 and 404. 5. Observation of the bathroom wall in resident room (202) on 6/1/12 revealed two holes under the hand sink. 6. Observation made of the hallway outside of resident room 332 on 5/31/12 at 12:30 PM revealed an isolation cart that was missing a wheel and was in disrepair. The cart was slanted and appeared it would fall at any time. 7 .On 6/8/12, debris was observed behind the ice machine of the second, third and fourth floor nourishment rooms. 8. The elevator carpeting was observed dirty throughout the survey and no-one was seen cleaning it. In the 1/3/12 resident council meeting notes, there was a concern made on: "no one cleans the room or the hallway". 9. On 6/11/12 at 9:00 AM, encrusted debris was observed in the wheelchair belonging to the resident in room 222. In an interview with E16	F 253	Areas identified have been corrected, and systems are in place for weekly tracking. In-servicing has been completed for housekeeping staff on June 21, 2012. Audits shall be completed weekly times 30 days then monthly times 60 days to determine compliance. This shall be the responsibility of the Director of Maintenance/Housekeeping Director. DOM/DOH shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance.	7/5/12

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F 253	Continued From page 5 (Housekeeping staff) on 6/11/12, she confirmed this finding. Additionally, encrusted debris was observed on the dust pan of a cleaning cart on the third floor on 6/11/12 at 8:30 AM. 10. On 6/8/12 and 6/11/12. debris was observed on the office space of the activity room where mice activity had been seen in March, April, and May 2012 per the pest control vendor report and a resident had seen mice in her room (on the same floor) for the May 2012 Memorial Holiday weekend. 11. An offensive odor was detected in the second floor hallway on 6/11/12 at 9:00 AM. E17 (Administrative staff - Medical Records Clerk) on 6/11/12 confirmed this finding. 12. On 6/11/12 at 9:15 AM, spider cobwebs were noted at the entrance bottom edge of the activity room common resident bathroom. Additionally in this same bathroom, a floor tile was observed in disrepair, behind the toilet the floor was un-cleanable; and the wall behind the toilet was observed dirty. In an interview with E17 on 6/11/12 at 9:15 AM about the cobweb, she indicated she would contact housekeeping. In an interview with E16 (Housekeeping staff) on 6/11/12 at 9:20 AM, she confirmed these findings. In an interview with E15 (Maintenance Director) on 6/11/12 at 3:00PM, he indicated he had a problem with the toilet and had it repaired by a vendor early May 2012 and had not gone back to repair the tile.	F 253		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

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F 280	Continued From page 6 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to revise the care plan for one (R56) out of 56 stage II sampled residents. Findings include: R56 had diagnoses including traumatic brain injury with anxiety and delusions and degenerative joint disease. On 5/18/12, R56 had an unwitnessed fall in the lounge adjacent to the nurses' station. Review of the incident report, dated 5/18/12,	F 280	7/5/12 Resident R56 remains in the center and has been reviewed by the ICP team and the plan of care has been reviewed and updated as necessary to reflect the resident's current level of care. Current residents are being reviewed at their next scheduled care conference to determine compliance. In-servicing shall be completed by 7/5/12, for licensed nursing staff on Care Planning. Random audits shall be completed weekly over the next 90 days to determine compliance. This shall be the responsibility of the DON/designee The DON shall report to the QA committee any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	

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F 280	Continued From page 7 revealed that R56 was found with one knee on the floor, sliding out of her wheelchair. The investigation revealed, "Additional Contributing Factors: Alarm was not on resident's chair". Review of the care plan entitled, "At risk for Fall", last revised 5/7/12 stated, "Bed/chair alarm in place while in bed, check placement/function q shift". The care plan failed to be revised to reflect the order on the 5/12 POS, originally written on 1/13/12, "personal alarm while out of bed at all times check placement and function every shift". On 6/8/12 in an interview, E6 (LPN) confirmed the findings.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview , it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care for two (R5, R56) out of 56 Stage 2 sampled residents. The facility failed to monitor R5's fluid restriction from 5/1/12 through 6/12/12.	F 309		

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F 309	Continued From page 8 Additionally the facility failed to ensure that a chair alarm was used and in place as ordered in the plan of care for R56. Findings include: 1. The facility policy entitled "10.4 Fluid Restriction," last revised on 6/1/09 stated, "Policy: When physician orders a fluid restriction due to specific clinical condition, close monitoring will be provided to maintain adequate hydration. Purpose: To maintain hydration requirements and monitor and promote compliance with fluid restriction. Procedure:...8. Document: 8.1 Intake in medical record..." R5 was admitted to the facility on 5/2/11 and had diagnoses that included hypertension, cerebrovascular accident (stroke), and end stage renal disease (ESRD). The 3/10/12 MDS (Minimum Data Set) assessment stated R5 was receiving dialysis services. A care plan for the focus at nutritional risk, last revised on 3/12/12 included the interventions "Provide diet as ordered. 1500 ml fluid restriction daily...4 oz house shake and hi protein snack daily at hour of sleep, Monitor for changes in nutritional/hydration status..." The 6/12 monthly physician's order sheet stated R5 was on a 1500 ml fluid restriction with the following allotment of fluids: breakfast-360 mls; lunch-240 mls; dinner-360mls; bedtime snack-120 mls. The remaining 420 mls were divided for nursing to administer 140 mls on each of the three shifts. Review of computerized CNA data revealed that	F 309	Resident R 5 remains in the center and continues to have his fluid restriction monitored per physician orders. And Resident R 56 remains in the facility and continues to use her chair alarm as ordered. Current resident with fluid restrictions and alarms have been reviewed to determine compliance. In-servicing shall be completed on or before 7/5/12, for nursing staff on Documentation of fluid restriction and alarm usage. Audits shall be completed weekly times 30 days and then monthly times 60 days to determine compliance. This shall be the responsibility of the DON/designee. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	7/5/12

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F 309	Continued From page 9	F 309		

fluid intake was not recorded as a separate entry, but instead a total amount of meal consumed (solids and liquids) was recorded. During an interview with E12 (Certified Nurse's Aide) on 6/12/12 at 10:40 AM, she confirmed that they document the entire amount consumed for a meal, which included the solids and fluids, and that there was not a separate option for documentation of fluids separately.

Review of the 4/12 medication administration record (MAR) revealed that the facility was documenting consumption of the 4 oz house shake at bedtime and documenting on each shift the amount consumed as per the allotted amount of 140 mls per shift.

Review of the MAR from 5/1/12 through 6/12/12, lack documented evidence that the fluid restriction allottment of 140 mls per shift for nursing was being followed and/or monitored. In an interview with E4 (Assistant Director of Nursing #2) on 6/12/12, she acknowledged that the fluid restriction allotment for nursing had not been monitored from 5/1/12 through 6/12/12 and that she had corrected the 6/12 MAR.

2. R56 had diagnoses including traumatic brain injury with anxiety and delusions and degenerative joint disease.

On 6/7/12, R56 was observed in bed with the bed alarm on in the morning and in the reclining rock and go chair with the chair alarm on in the afternoon.

The annual Minimum Data Set (MDS)

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F 309	Continued From page 10 Assessment, dated 10/27/11 and the quarterly MDS, dated 4/15/12, both coded that R56 was severely cognitively impaired, required extensive assistance of two persons for transfer, had balance that was not steady and was only able to stabilize with human assist, and had a fall history of 2 or more falls with no injury since the previous assessment. Review of R56's physician order sheet (POS) for May, revealed an order that stated, "personal alarm while out of bed at all times check placement and function every shift". Review of the incident report, dated 5/18/12, revealed that R56 was found with one knee on the floor, sliding out of her wheelchair. Despite documentation of the alarm being in place on 5/18/12 on the May Medication Administration Record, the investigation revealed, "Additional Contributing Factors: Alarm was not on resident's chair" The facility failed to follow the plan of care on 5/18/12 when R56 did not have the chair alarm as ordered in the plan of care.	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined that the facility failed to maintain the environment free from accidents hazards, as evidenced by accessible and unlocked treatment carts, supply room, janitor closet, oxygen tanks, portable food steam tables, carving knife, with hazard potential on each of the three floor residents wings. Findings include: 1. Observations of the fourth floor supply room on 6/1/12 at 8:30 AM revealed the door was unlocked and contents were accessible to residents and visitors. Medical and resident care supplies such as wound cleaners, shaving creams, 8-oz sanitizer bottles, one bottle of hydrogen peroxide were stored in this room. E18 (Nurse) on 6/1/12 confirmed this finding. 2. Observations of the fourth floor South hallway on 6/8/12 at 9:35 AM with E19 (Laundry staff) revealed a treatment cart top drawer was unlocked and contents were accessible to residents. The cart was not within E20's (Nurse) view, who was inside a resident room three doors down from the cart administering medications. After bringing this to the attention of E20 on 6/1/12, she stated she had been gone for a few minutes and was then observed locking it. E20 confirmed she had left the cart unlocked. On 6/8/12 at 9:50 AM, the same treatment cart was again observed unlocked in the same location. Additionally on 6/1/12 at 11:50 AM on the third floor hallway, a treatment cart top drawer was opened by the surveyor. Although the lock was in	F 323	All environmental accident hazards have been corrected. In-servicing for nursing staff shall be completed on or before 7/5/12, on locking supply rooms, treatment carts, nourishment rooms, and oxygen room to maintain resident safety. In-servicing for housekeeping staff shall be completed on or before 7/5/12, on locking janitor closets. In-servicing for dietary staff shall be held on or before 7/5/12, on steam table safety from turning off after use, and proper storage of sharp objects away from resident areas. Random rounds shall be completed monthly times 3 months to determine compliance. This shall be the responsibility of the Administrator/designee. The Administrator shall report to the QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	7/5/12

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F 323	Continued From page 12	F 323		

place on the cart, the top drawer was able to be opened. In an interview with E8 (Nurse) on 6/1/12, she confirmed this finding and stated she would contact maintenance.

3. Observation made on 5/31/12 with E6 (MDS Coordinator) revealed the fourth floor janitor closet was unlocked and contents accessible to residents. The room stored cleaning chemicals and biohazard materials. E6 confirmed the room should be locked.

4. Observations of the fourth floor nourishment room on 6/1/12 at 9:50 AM revealed the door was unlocked with contents accessible to residents and visitors. The door to this room had a padlock on the door knob and a sign stating the door was to be kept locked. This room stored an ice machine, a refrigerator and food and medical supplement supplies. E15 (Maintenance Director) confirmed this finding.

5. Observations of the fourth floor hallway on 6/7/12 at 10:55 AM with E6 (MDS Coordinator) revealed an oxygen room unlocked and contents accessible to residents and visitors. The room stored oxygen tanks in a crate inside the room. The door had a label stating "Oxygen".

In an interview with E6 on 6/7/12, she stated that she could not lock the room as the pad lock did not work, that this was a safety concern, and that she would contact the maintenance director (E15). On 6/11/12, E15 confirmed that he had to order a new door for this oxygen tank storage room.

6. Observations of the first floor dining room on

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F 323	Continued From page 13 6/4/12 at 1:25 PM revealed two hot portable steam tables that were on and accessible to residents and visitors although no-one was in the room. The door to this dining room was observed opened at all times during the day throughout the survey. The temperature of the steam table water was tested at 179 degrees Fahrenheit and above hot water temperatures in which they could burn your skin upon contact. In an interview with E21 (Dietary Director) and E22 (Dietary staff) on 6/4/12, E21 confirmed this finding. In an interview with E22 on 6/4/12 at 2:00 PM, she stated that the dining room was kept open at all times and that the steam tables were left on between meals. E21 on 6/4/12 indicated that the steam tables needed to be off after each meal and were supposed to be turned on when they were ready to serve the meals in the dining room. Review of the third floor residents' cognition level, which would be exposed to the third floor dining room and the hot steam tables, revealed that only one resident (R113) was cognitive impaired yet was supervised during the meals. 7. Observations of the first floor dining room on 6/4/12 at 1:25 PM revealed a large carving knife inside one unlocked drawer in the kitchenette area of the dining room that posed a hazard. E21 confirmed this finding on 6/4/12.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or	F 329		

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F 329	Continued From page 14 without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that each resident's drug regimen was free from unnecessary drugs when used without adequate monitoring for one (R56) out of 56 stage II sample residents. Findings include: R56 had diagnoses including congestive heart failure, coronary artery disease and elevated lipids. R56's physician ordered Metoprolol Tartrate 50 mg one tablet twice a day for hypertension with parameters to hold the medication for a systolic	F 329	Resident R 56 continues to receive her prescribed medication with adequate monitoring as ordered by the physician An audit of current resident's drug regime was completed to maintain continue compliance with monitoring Blood Pressures and Heart Rate as ordered by the Physician Licensed Nursing Staff will be re-educated on or before 7/5/12 on monitoring Blood Pressures and Heart Rate per physician's orders. Random audits will be completed monthly for the next 3 months by the DON/designee to determine adequate monitoring per physician orders to determine continued compliance. The DON shall report to the Administrator and QA Committee monthly any variances in the data collected. The QA Committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance	7/5/12

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F 329	Continued From page 15 blood pressure less than 100 or heart rate (HR) less than 60. Review of the 2/12 MAR for R56 revealed that the blood pressure (B/P) and HR were not being monitored for Metoprolol as per the physician's order. On 2/7/12 the B/P was blank for the 9 AM dose and on 2/25/12 at 9 AM the HR was blank when Metoprolol was documented as given. Also, the HR was not being monitored with 23 blanks for the 9 PM dose of Metoprolol when the medication was documented as given. Review of the 3/12 MAR for R56 revealed that the B/P and HR were not being monitored for Metoprolol as per the physician's order. Blood pressures were blank for 3/1, 3/6, 3/10, 3/11 and 3/20/12 at 9 AM as well as 3/1 through 3/6 and 3/11/12 at 9 PM when Metoprolol was documented as given. Also, the HR was not being monitored for Metoprolol at 9 PM for the entire month. Review of the 4/12 MAR for R56 revealed that the HR was not being monitored and parameters not followed for Metoprolol as per the physician's order. At 9 AM on 4/2/12 with a HR of 59, on 4/29/12 with a HR of 58 and on 4/30/12 with a HR of 56, the 9 AM Metoprolol was documented as given. Also, the HR was not being monitored for Metoprolol at 9 PM with 24 blanks during the month. Review of the 5/12 MAR for R56 revealed that the HR was not being monitored and parameters not followed for Metoprolol as per the physician's order. On 5/2/12 with a HR of 52, the 9 AM Metoprolol was documented as given. On 5/7/12	F 329		

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F 329	Continued From page 16 with a HR of 56 and on 5/8/12 with a HR of 58 the 9 AM doses of Metoprolol were circled which indicated not given but then on the back of the MAR, it stated, "held, error given". Also, the HR was not being monitored for Metoprolol at 9 PM with 27 blanks during the month. Review of the 6/12 MAR for R56 revealed that the HR was not being monitored for Metoprolol as per the physician's order. The HR was not being monitored for Metoprolol which was blank 4 times, only monitored twice for Metoprolol at 9PM from 6/1 - 6/6/12. On 6/7/12 in an interview with E4 (ADON #2), confirmed the findings.	F 329		
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to	F 356	Staffing is posted daily per regulations. Staffing sheets shall be maintained per regulation. In-servicing has been completed for the staffing manager on posting of staffing and maintenance of records. Random audits shall be monitored by the Administrator for compliance. The Administrator shall report to the QA committee any variances in the data collect. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance.	7/5/12

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F 356	Continued From page 17 residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined the facility failed to post on a daily basis, in a prominent place readily accessible to residents and visitors at the beginning of each shift, the total number and actual hours worked by staff directly responsible for resident care per shift: Registered Nurses, Licensed Practical Nurses, and Certified Nurse Aides. The facility also failed to maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Findings include: 1. Observations made on 6/1/12 at 10:10 AM of the second floor nursing station revealed Nurse Staffing Information posted that lacked the total hours for the RN's, LPN's and CNA's that had worked. Additionally, the staffing information was observed laying flat on the 2nd floor nursing station table (as the plastic holder was broken) and was not readily accessible to residents unless they specifically asked to see it. In an interview with E4 (ADON) on 6/1/12, she confirmed this finding.	F 356		

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F 356	Continued From page 18 Additionally, the staffing information was missing and was not posted in the third floor nursing station on 6/1/12 at 9:15 AM. In an interview with E23 (CNA), she confirmed this finding. 2. On 6/7/12 at 2:30 PM, observations of the third floor and 2nd floor nursing station with a second surveyor revealed Nurse Staffing Information posted that lacked the total hours for the RN's, LPN's and CNA's that had worked. In an interview with E3 (ADON) on 6/7/12 at 2:34 PM, she confirmed this finding.	F 356		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations made in the dietary department and staff interviews, it was determined that the facility failed to prepare, serve and distribute food under sanitary conditions. Findings include: 1. Observations made of the reach-in refrigerator in the kitchen on 5/31/12 at 10:45 AM revealed the following:	F 371	No negative resident outcomes reported as a result of the deficient practices. Areas identified were immediately addressed and corrected. Inservicing will be held on or before 7/5/12 for dietary employees on proper labeling/dating, safe hot/cold holding temps of foods, three compartment sink; proper storage of cleaning cloths and cleaning procedures. Random audits will be conducted monthly for the next 3 months by the FSD/designee to determine compliance. Results of the audits will be reported to the QA committee for recommendations as necessary to obtain and maintain compliance	7/5/12

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F 371	Continued From page 19 a. An opened 32-oz container of pasteurized eggs was missing the date in which the container was opened and removed from the box. In an interview with E24 (Assistant Food Service Director) on 5/31/12, she stated that the egg container needed to have a date and confirmed this finding. b. An opened 16-oz container of "Legout" chicken base was undated. c. An opened large container (of five) of Yoplait yogurt was undated. d. An opened plastic bag of Whoop cream was undated. e. A pre-made 5-gallon plastic container of lemonade was undated and did not indicate when it was made. f. A tray containing approximately 18 glasses of apple juice, 3 glasses of chocolate milk, and a few glasses of lemonade and ice tea were undated. g. Three trays containing roughly 40 containers of thawed 4-oz vanilla shakes on each tray, were undated. The individual vanilla milk shake containers were undated and did not indicate the date when they were taken out of the freezer and placed in the refrigerator to thaw out. A line on the side of each milk shake container, to indicate the date when the container was removed from the freezer and placed in the refrigerator and the date the shake was thawed out, was blank for all containers on the three trays.	F 371		

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F 371	Continued From page 20 In an interview with E21 (Dietary Director) on 5/31/12, he stated that "they usually put a date and kept the food for 14 days". E21 confirmed the containers should have had a date on them. 2. Observation of the 2nd floor nourishment room reach-in refrigerator on 6/8/12 at 11:25 AM revealed a disposable cottage cheese container was uncovered and undated. Additionally on 6/8/12 at 11:35 AM, the fourth floor nourishment room reach-in refrigerator was observed with a vanilla milk shake container that had been thawed without a date. During an interview with E25 (LPN) on 6/8/12, he confirmed there was no date and discarded the container. In an interview with E21 on 5/31/12, he stated that they use the food for three days after it is opened. 3A. Observation of the walk-in freezer in the kitchen on 5/3/12 at 11:30 AM revealed the following: a. Two bags of "Bacalao (Salty Fish)", one opened and the other not opened, were undated. In an interview with E21 on 5/31/12, he stated that he was planning to discard them. b. On 5/31/12, one bag of Brussel sprouts was observed on top of another unrelated food box undated inside the freezer. In an interview with E21 on 5/31/12, he confirmed this finding. 3B. Observations of the milk box/refrigerator in the kitchen on 5/31/12 at 11:15 AM revealed four unopened pint milk containers with brown dirt	F 371		

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F 371	Continued From page 21 around the external surface of the containers. E21 discarded the milk containers. 3C. Observation of the reach-in refrigerator in the first floor dining room on 6/4/12 at 1:25 PM revealed the following food items that were undated: - 2 packs of yellow cheese wrapped in plastic - An opened container of liquid whole egg (1 pint) - A cardboard tray of whole eggs. In an interview with E21 on 6/11/12, he revealed the food items should have been dated. 4a. Observations made in the kitchen on 5/31/12 at 11:15 AM revealed the ice machine with a 1/4 drain pipe touching the dirty grate on the floor and without an air gap. In an interview with E21 on 5/31/12, he confirmed this finding and stated he would contact E15 (Maintenance Director). Additionally on 6/8/12, the second and fourth floor nourishment room ice machine drain pipes were observed with the drain pipe touching the floor flange and not exhibiting an air gap. In an interview with E15 on 6/8/12, he stated he would check these drain pipes as they should have an air gap. 4b.Observation of the dishwasher drain pipe in the kitchen on 5/31/12 revealed the drain pipe touching the grate on the floor and without a gap. 5. Observation of the co-ed dietary staff bathroom outside the kitchen on 5/31/12 at 11:35 AM revealed a trash can in the bathroom that was uncovered. E21 confirmed this finding.	F 371		

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F 371	Continued From page 22 6. Observation of the kitchen area on 5/31/12 at 11:20 AM revealed an uncovered rack of clean, and sanitized eating utensils under a table across the steam table. The potential for contamination existed, as the area was the pathway for the staff to the outside of the kitchen. E21 confirmed this finding. 7. On 5/31/12 at 11:15 PM, a test of a bottle containing sanitizing solution was done by E21 revealing traces of the sanitizer, or no sanitizer, in the test strip. E21 stated they filled up the bottle each morning from the 3-compartment sink and they tested it at 8 AM measuring 200 PPM. He stated the chemical vendor had tested the solution in the 3-compartment sink early during this week and E21 stated that his sanitizing solution was fine since the 3-compartment solution concentration was fine. He was unaware how long it took for the solution in the bottle to dissipate once placed in the bottle and used it to clean equipment in the kitchen. E21 stated they test the sanitizing solution at 8AM and at 12 noon each day. 8. Observations of two gray buckets in the kitchen on 5/31/12 at 11:15 AM revealed one to two rags stored inside a yellow solution that did not contain sanitizer. The buckets were used to place soap and clean kitchen equipment. In an interview with E21 on 5/31/12, he stated he was unaware that they had to store soiled rags inside a sanitizing solution per requirements in the 2011 Delaware Food Code. 9. Observation of the kitchen area on 5/31/12 at 11:50 AM revealed a tile (or molding strip)	F 371		

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F 371	Continued From page 23 missing from the wall by the freezer area and a wall that was un-cleanable. Additionally, a broken tile was observed on the wall behind the dishwasher. 10. Observation of the kitchen area on 5/31/12 at 12:10 PM revealed heavily encrusted debris on the dishwasher floor grate. Additionally, a dust pan in the kitchen was observed with encrusted debris and it was stored at the far right side of the 3-compartment area in the kitchen. 11. Observations made of the portable steam table used to serve food from in resident rooms on 5/31/12 at 12:25 PM revealed E24 (Assistant Food Service Director) serving food to residents on plates that were chipped. Two of nine plates were observed to be chipped during service on the third floor. Additionally, during a second dining observation on the fourth floor on 6/8/12 at 8:10 AM, two out of 15 plates used to serve breakfast were chipped. The finding was reviewed with and confirmed by E21 on 6/8/12 at 8:26 AM. E21 proceeded to remove the chipped plates from under the steam table and placed them on a cart going back to the kitchen. 12. During the first dining observation of the third floor on 5/31/12 at 12:32 PM, the surveyor requested that E24 (dietary staff) test the food stored on the portable steam table as the surveyor had not observed testing of the food since the food left the kitchen at 11:50 AM. The puree vegetable peas were tested at 122 degrees Farenheit (F). At that point, E24 asked another dietary staff to bring the other container of	F 371		

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F 371	Continued From page 24 vegetables. The portable steamer was then observed being taken to the fourth floor at 12:40 PM. On 5/31/12 at 12:55 PM, the surveyor requested E24 to test the regular pork from the steam table and others at random. Using a dial thermometer, the pork was tested as being at 120 degrees F. E24 was observed telling another dietary staff to get the other pan of pork from the other hot box. On 5/31/12 at 12:55 PM, E24 confirmed the pork temperature was low. E24 was observed telling another dietary staff to "put this back" in reference to the pork that tested 120 degrees Fahrenheit. Additionally, during the second dining observation on the fourth floor on 6/8/12 at 8:27 AM, food temperatures at the portable steam table were tested after being prompted by the surveyor. The temperatures of the food were measured below 135 degrees F (required temperatures per the Delaware 2011 Food Codes to prevent food-borne illness) and were as follows: omelets =120 degrees F, fried eggs=120 degrees F. All other foods were above 135 degrees F. The staff was not observed temping the food prior to serving the food when they arrived at the fourth floor from the third floor at 8:10 AM on 6/8/12. In an interview with E21 (Dietary Director) on 6/8/12, he stated, "Food was supposed to be tested at each floor and the food replaced if the temperature was below the required values, but they failed to do temp the food and replace food from the other box". Review of the food temperature log book with	F 371		

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HILLSIDE CENTER	810 SOUTH BROOM STREET WILMINGTON, DE 19805

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F 371	Continued From page 25 E27 revealed the food had not been temped when the steam table arrived on the fourth floor. E27 confirmed that they had temped the food on the third floor, but had not temped it upon arrival to the fourth floor prior to serving. 13. On 6/8/12, E26 (dietary staff) was observed using the dial thermometer to test the fried egg without first sanitizing it after having tested the temperature of the egg omelets, which were temped at 120 degrees F. Food Codes requires that the thermometer be sanitized between foods that are not meeting the required guidelines. In an interview with E21 on 6/8/12, he confirmed that the staff should have sanitized the thermometer. 14. During the dining observation on 5/31/12 at 1 PM, the steam table cart arrived onto the 2nd floor. E26 (Dietary staff) was serving lunch to residents in their rooms and after the following observations, E26 continued to serve food to residents with contaminated gloves. At 1:10 PM, E26 was observed scratching his left eyebrow with his gloved hand. Then, E26 held onto the hand rail with his gloved hands. At 1:20 PM, E26 picked up walkie talkie with his gloved hand. Then, an observation was made of E26 with a ripped glove on his left hand. The facility failed to serve food under sanitary conditions. On 5/31/12 at 1:50 PM, in an interview, E26 confirmed the findings. E26 also stated that the gloves were too small for his hands and that is why they ripped. 15. On 5/31/12 at 1:25 PM, E24 (Dietary staff)	F 371		

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F 371	Continued From page 26 was observed plating the food on the steam table cart on the 2nd floor. An observation was made of E24 removing her gloves, picking up and speaking into the walkie talkie, then placing it (walkie talkie) inappropriately on the serving surface. The facility failed to serve food under sanitary conditions. On 5/31/12 at 2:05 PM, in an interview, E24 confirmed the findings. 16.On 6/8/12 at 8:10 AM, the food arrived in a steam table cart and a second dining observation was made on the 4th floor. E26 who was plating the food, was observed pushing the cart with his gloved hand and then returned to plate the food with contaminated gloves. E26 handled utensils and picked up toast with his contaminated gloved hands. The facility failed to serve food under sanitary conditions. On 6/8/12, findings were confirmed by E21 (Dietary Director). 17.Observation of the fourth floor hallway on 5/31/12 at 1:00 PM revealed E26 (dietary staff) while wearing gloves, touching the door frame of room 430, going inside room 429, then going out to the portable steam table, placing his hands on the top of the table (clean side), rubbing his hands on his black uniform/pants, picking up a food plate with a soup bowl on the top of the plate, and taking it to room 429. He then proceeded to take food to other residents' rooms. E26 had gloves on during this time and did not wash his hands and change gloves after touching dirty surfaces and then serving residents' food.	F 371		

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F 372 SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation of the dumpster area and interview, it was determined that the facility failed to dispose of garbage and refuse properly. Findings include: Observation on 5/31/12 at 11:35 AM with E21 (Dietary Director) of the platform leading to the dumpster area outside the kitchen revealed a dirty toilet waiting to be disposed of, various soiled empty milk crates, and cardboard. Numerous small black flies were observed hovering around the trash and in the air. E21 stated he would contact maintenance in regards to the dirty toilet, and stated that the milk vendor would pick up the crates. He also stated that they treated the area and had an air system on the door so that whenever the door was opened, the flies could not come into the building. Observation of the door on 5/31/12 with E21 revealed an air system on the door to the entrance of the facility outside the kitchen.	F 372	The dumpster and loading dock area have been cleaned. The area is being cleaned on a routine basis. In-servicing has been completed for housekeeping staff on cleaning of loading dock and dumpster area. Daily rounds shall be completed over the next 90 day to determine compliance; this shall be the responsibility of the Housekeeping Director/designee. The Housekeeping Director shall report to the Administrator and QA any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	7/5/12
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all	F 431		

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F 431	Continued From page 28 controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, it was determined that the facility failed to ensure that the drugs and biologicals that were stored in the medication refrigerators were not expired. Findings include: 1. An observation on 5/31/12 at 2:25 PM of the third floor medication refrigerator with E8 (nurse)	F 431	Refrigerators on each floor have been checked to determine no expired drugs or biologicals were being stored. No residents received expired medications. Licensed Nurses and Pharmacy Consultants were re-educated on or before 7/5/12 on routinely checking the refrigerators for expired drugs and biologicals and disposing accordingly Random audits will be completed monthly for 3 months by the Consultant Pharmacist and/or Licensed Nurses to determine no expired drugs or biologicals are being stored. The Consultant Pharmacist shall report to the Administrator and QA Committee monthly any variances in the data collected. The QA Committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance	7/5/12

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F 431	Continued From page 29 revealed one (1) open bottle of liquid Vancomycin 250mg/5ml for R191 stored inside that had expired on 5/23/12. E8 confirmed the medication was expired and disposed of it. 2. An observation on 6/1/12 at 3:15 PM of the second floor medication refrigerator with E9 (nurse) revealed one vial of Pneumovax vaccine that had expired on 2/5/11. This vial was stored inside of a plastic medication bottle/container with an affixed label that had an expiration date of 6/22/11 for R61.E9 stated that the vaccine was expired and disposed of it.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441		

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F 441	Continued From page 30 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: The facility failed to ensure staff maintained a safe, sanitary and comfortable environment and to help prevent infection. A wound care nurse failed to follow proper handwashing practices five (5) times consistent with accepted professional standards practices during a wound dressing treatment for R 117 to prevent the spread of infection. During a sacral wound dressing change for R89, E7 (wound care nurse) failed to wash hands after removing the old dressings and before changing gloves and throughout the procedures. The facility failed to implement signs to identify a resident on contact precaution, failed to analyze organisms and develop variance reports to allow them to implement an effective action plan for infection control. During Findings include: 1. Stage 4 sacral wound dressing changed with wound VAC for R117 performed by E7 (LPN) was observed on 6/8/12 at approximately 2:30 PM.	F 441	Residents R 89 and 117 remain in the center and continue to receive wound care using proper hand washing procedure. Proper hand washing procedure is being maintained for any other residents with wound care. Isolation signs have been posted on resident rooms to identify isolation. Identified Infection Control nurse has been educated on the proper completion of the infection control forms. Infection control logs are being completed properly on a monthly basis and trending is being completed along with identification of organisms. In-servicing has been completed for E7 on hand washing. In-servicing shall be completed on or before 7/5/12 nursing staff on hand washing. In-servicing for center staff shall be completed on or before 7/5/12 on isolation signage. Random audits shall be completed weekly for the next 30 days and then monthly for 60 days to determine compliance. This shall be the responsibility of the Infection Control Nurse/designee. The IC nurse shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance.	7/5/12

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F 441	Continued From page 31 The spray can container of the normal saline solution and the loose cover were left on top of R117's bed with the resident's bed linen partially covering the mouth of the spray can throughout the wound dressing procedure and was not cleansed with an alcohol wipe/disinfecting agent before saving it for future use. E7 (LPN) failed to follow proper handwashing practices consistent with accepted professional standards of practice five (5) times during wound dressing treatment for R 117 to prevent the spread of infection. R117 had a debrided stage 4 sacral wound with a wound vac canister (a treatment procedure that delivers negative pressure (a vacuum) at the wound site, draw wound edges together, remove infectious material and promote granulation of tissue). The sacral wound measured 2. 5cm Long x 2.5 cm Wide x 2.9 cm Deep, granulating, with small amount of slough, no exposed bone. Based on record review, R117's sacral wound had a history of MRSA infection on 01/16/12. The wound treatment included "Black granulofoam wound vac (vacuum) to 125mH/gm (mercury) to be changed on M-W-F (Mondays, Wednesdays and Fridays). A wound dressing change and changing of the black granulofoam performed by E7 (LPN) was observed on 6/8/12 (Friday) at approximately 2:00 PM. E7 gathered the necessary equipment which consisted of a Spray can of Saline solution,	F 441		

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F 441	Continued From page 32 Restore 4x4 (help to absorb wound exudate and protect the surrounding skin for maceration), Tegaderm (transparent film dressing) and a VAC dressing kit on top of R117's bedside table on a set up clean barrier. An appropriate plastic lined trash container was also set up. E7 (LPN) washed hands on the sink adjacent to the bedside table and dried hands with a clean paper towel and donned a new pair of clean gloves. E (LPN) proceeded to removed the Acticort (hydrocortisone topical steroid to relieve inflammation and itch) from inside the wound bed, inspected and discarded the old soiled dressings and gloves into the appropriate trash container. Without handwashing E7 (LPN) donned a new pair of clean gloves and cleansed the wound by using a spray can of saline solution. E7 (LPN) without handwashing, replaced her contaminated gloves with a new pair of clean gloves again, finished the wound cleansing, and removed the old wound vac tubing from the wound and dumped it into the appropriate trash can. E7 (LPN) removed her soiled gloves again without handwashing donned a new pair of clean gloves. She then picked up a pair of standard large scissors (use for cutting hair or fabric) on the seat cushion of R117's chair and without cleaning the scissors with an alcohol wipe, she used it to cut the prescribed Restore pad (absorb wound exudate and helps protect the surrounding skin from maceration) to size, before she could place it on the wound and under the wound vac.	F 441		

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F 441	Continued From page 33 She then used Tegaderm tape as a transparent drape material onto the periwound approximately an inch all around. She cut and shaped the black foam to fit the size of the wound with the same contaminated scissors. With her gloved hands, E7 (LPN) opened R117's dresser drawer to get a cotton tip applicator and continued to proceed with the dressing treatment using the same contaminated gloves. E7 (LPN) removed her soiled gloves, again opened the resident's dresser drawer, did not find what she was looking for, went out of the room without handwashing and returned with another VAC dressing kit which she stated she got from the supply room. E7 confirmed that she failed to wash hands before leaving the resident's room while in the process of performing the treatment and before entering the supply room to get another wound vac kit that she needed. E7 (LPN) washed her hands and donned a new pair of clean gloves and proceeded with the placement of the wound vac. on the wound. She then placed the shaped black foam in the wound and applied a transparent material to cover the foam and wound. With the same contaminated scissors, she cut a hole in the transparent drape, applied over the hole a rounded pad with plastic tube and connected the tubing from the dressing to a tubing coming from the VAC suction unit. E7 (LPN) failed to handwash before changing gloves 5 times during the wound care treatment and failed to follow proper aseptic wound care technique/procedures.	F 441		

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F 441	Continued From page 34 This was discussed with E7 (LPN) on 6/8/12 and with E1 (Administrator) on 6/12/12. 2. Observation on 6/7/12 of R89 during a sacral wound dressing change with E7 (nurse) revealed that E7, after removing the old dressing and discarding in the trash, did not wash her hands before putting on clean gloves and then continued with the wound care and application of a new dressing. The facility policy entitled, "Dressing: Aseptic" dated 6/1/09 states, " Procedure ...#13 Expose area to be treated. 13 1 Apply clean gloves and remove the soiled dressing. 13 1 Discard dressing and gloves according to infection control policy. #14. Cleanse your hands. #15. Apply clean gloves. " Findings were confirmed with E1 (Administrator) on 6/11/12. 3. Observation of the third floor hallway on 5/31/12 at 12:30 PM revealed an isolation cart outside room 332. The door to the room did not have a sign indicating to stop and see the nurse before entering. Other resident rooms with an isolation cart outside were observed with this signage. An observation was made of a dietary staff (E26), which was distributing food plates from a portable steam table revealed the staff knocking on the door of room 332, going inside the room to talk to the resident, and going out again to the steam table without washing hands	F 441		

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F 441	Continued From page 35 or using sanitizer. The staff continued to serve food to other rooms. Review of the Infection Control Policies and Procedures, entitled " 3.1 Contact Precautions", under "Process" (#2) documented "Place a STOP. Please see nurse before entering the room" sign on door. The procedure indicated the purpose was "to reduce the risk of transmission of epidemiologically important organisms by direct or indirect contact". 4 . Review of the facility infection control data from January to May 2012 with E30 (Infection Control Nurse) on 6/8/12 revealed that although the facility had line listings, analysis, trend charts and variance reports with action plans, the infection data lacked the infections' organism and the variance reports were not completed consistently. The facility infection control policies and procedures were reviewed. Review of the infection control data revealed that the facility kept infection data and reports as follows: - Infection listing reports by resident names, room number, admit date, onset date, N/C, type of symptom/diagnoses, date cultured (date taken, site, and results, treatment, precaution type, infection resolved. The line listing reports had no organisms listed and were recorded occasionally on the diagnosis line but were not consistently tracked. - Surveillance data of MDROs (Multi-Drug Resistant Organism) from January to May 2012 on the same form. MDRO included only c-diff,	F 441		

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F 441	Continued From page 36 VRE urine, MRSA. - Monthly infection control reports for each floor indicating the site of infection such as urinary track, respiratory, etc and whether they were community acquired or nosocomial. This analysis showed the total number of the infections and total samples of residents cultured indicating the culture results as either being positive or negative. - In house acquired infections - focused surveillance trending per month (Jan-May) and number of infections; and a plot of that data to easily visualize data trends per month by unit. - Reports of "nosocomial infection rate - tracking and trending - variance analysis" by month, analysis of trends indicating what changed, commonalities or clusters identified, possible causes, and their plans for further monitoring/intervention. For example in January 2012, the facility trained staff on infection control, blood borne pathogens, proper PPE (Personal Protective Equipment), hand washing between residents and when removing gloves. The IC data appeared different each month, the organisms were missing from the line listings, and sometimes the data showed at times an organism for a couple of infections, and the variance analysis reports were not available for a few months. In an interview with E30 on 6/8/12 at 10:36AM, on the program and the infection data and after review of the data with her, she revealed she was new to this position (since May 2012), the previous IC staff (E31) was no longer at the facility, and she confirmed this finding. She stated that "the organisms were not listed for all	F 441		

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F 441	Continued From page 37 residents on the January to May 2012 line listing report to accurately analyze infections trends". She also stated and confirmed that they lacked a variance report for January 2012, March 2012, and April 2012 to consistently determine what action plans they took". There was a variance report for February and May 2012. E30 stated that the organisms were not listed for all months, and at times in some reports, they were written up in the diagnoses but were not listed for everyone. She stated that the focused surveillance trending report generated by the computer was done using the data she put in it. The graph was populated and that helped with trending analysis and eyeballing the infections. She stated she looked at the laboratory reports for organisms but that they were not documented in the line listing.. She stated "she may be able to see more a trend if she had the organisms in the report". E30 confirmed she was missing variance report for January 2012 March 2012, April 2012. The variance reports she stated, documented their actions plans and recorded clusters they saw of the data. She confirmed that there two issues with the IC data, that the organisms are not listed for everyone to accurately analyze trends of infections and the other issue that they did not do a variance reports consistently to track action plans taken."	F 441		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing	F 463	Resident R56's call light has been fixed. Rounds have been completed and no other issues were identified.	7/5/12

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F 463	Continued From page 38 facilities. This REQUIREMENT is not met as evidenced by: Based on review of resident room call system functionality, it was determined that the facility failed to maintain a properly functioning call system for R56's bedroom. Findings include: Observation of R56's emergency call light on 6/1/12 at 10:50 AM revealed that when the bedroom call light was activated, it lacked sound and had no light above the doorway. All other call bell units tested functioned properly. In an interview with E14 (Nurse), she confirmed this finding and stated she would contact maintenance to fix it, and that R56 could not use the call bell.	F 463	In-servicing shall be completed on 7/5/12 for facility staff on Maintenance notification of facility issues related to facility call light system. Random rounds shall be completed weekly for the next 30 days then monthly for 60 days to determine compliance. This shall be the responsibility of the Director of Maintenance. The Director of Maintenance shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	
F 467 SS=E	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to maintain adequate ventilation by means of windows, or mechanical ventilation, or a combination of the two as reflected by malfunctioning exhaust vents in the North wing for all floors resident bathrooms. Six resident bathroom exhaust vents were tested 202, 221, 230, 327, 329 and 425. Findings	F 467	The exhaust systems effecting rooms 202, 221, 230, 327, 329, and 425 have been repaired. No other issues have been identified. To ensure proper operation of the exhaust system the Maintenance Director or designee will complete a weekly audit of the exhaust system in all areas throughout the building. The Maintenance Director shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	7/5/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085013	A. BUILDING _____ B. WING _____	C 06/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE CENTER	810 SOUTH BROOM STREET WILMINGTON, DE 19805

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F 467	Continued From page 39 include: Observations made during the environmental tour of the facility on 6/1/12 with E15 (Maintenance Director) revealed an odor in the bathroom of resident room 230. The exhaust vent in the bathroom was not drawing air into the vent or working. Other exhaust vents of resident bathrooms were tested and were not working in rooms 202, 221, 327, 329 and 425. E15 stated that the resident bathroom exhaust vents on the North side of all three floors were connected to the same motor on the roof and he would check the motor. On 6/8/12, E15 confirmed that the exhaust vent motor had to be repaired.	F 467		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that	F 514		

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F 514	Continued From page 40 clinical records were maintained in accordance with accepted professional standards and practices that were complete and accurately documented for five (R14, R56, R65 R170 and R186) out of 56 stage II sampled residents. Findings include: 1. R56's physician ordered Metoprolol Tartrate 50 mg 1 tablet twice a for hypertension with parameters to hold the medication for a systolic blood pressure less than 100 or heart rate (HR) less than 60. Review of the 6/12 Medication Administration Record (MAR) revealed on 6/5/12 and 6/6/12, the 9 AM doses of Metoprolol were documented as given despite being outside of the HR parameter, less than 60. On 6/8/12, in an interview with E20 (LPN), regarding the 9 AM Metoprolol administration on 6/5 and 6/612, she stated that she held the Metoprolol but that she must have "been busy" and did not circle to indicate that it was not given and did not write on the back of the MAR that it was held and the reason why. When asked if that was her usual practice? E20 stated that she must have been busy but again denied that she gave the Metoprolol on those dates. The facility failed to have accurate documentation on the 6/12 MAR for R56. 2. On 6/1/12 at 11:35 AM, review of R65's May 2012 MAR (Medication Administration Record) lacked evidence that R65 received his medications timed for 9 AM (Aspirin, Bentyl,	F 514	Refer to F 329 for Medication Monitoring Resident R186 is no longer a resident in the center Resident R 65, R 14 continue to receive their medications as ordered by the physician Review of current residents was completed to determine that no other residents were affected. Licensed Nursing Staff will be re-educated on or before 7/5/12 on following accepted professional standards to include but not limited to policy on administering and documenting medications as ordered by the physician Random observations of medication administration and documentation of same will be completed by the DON/designee monthly for3 months to determine continued compliance. The DON shall report to the Administrator and QA Committee monthly any variances in the data collected. The QA Committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance	7/5/12

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F 514	Continued From page 41 Lasix, Hydralazine, Meclizine HCL, Senna Plus, Simethicone, Spiriva, and Flomax) on 6/1/12. During an interview immediately following this record review, E14 (nurse) stated that she administered R65 his 9 AM medications but failed to document it. During an interview on 6/1/12, R65 confirmed that he had received his morning medications. During an interview, findings were acknowledged by E4 (ADON #2) at 11:40 on 6/1/12. She informed E14 that documentation was supposed to be done as part of the medication pass. 3. On 6/1/12 at 11:35 AM, review of R14's May 2012 MAR lacked evidence that R14 received her medication timed for 9 AM (Spiriva) on 6/1/12. During an interview on 6/1/12, E14 (nurse) stated that she gave R14 her 9 AM medication but failed to sign it off. During interviews on 6/1/12, findings were acknowledged by E3 (ADON #1) and E4 (ADON #2). 4. During a Medication Pass observation on 6/1/12 at 7:50 AM, E13 (nurse) was observed administering medications to R186 that included Janumet (timed for 7:30 AM), and aspirin (timed for 9 AM). R186 had a physician's order for a daily dose of Senna which was unavailable for 9 AM. E13 received a physician's order to administer R186's daily dose of Senna when it became available at 1 PM.	F 514	Resident R 170 remains a current resident in the center. A care plan addressing his potential discharge has been completed. The center continues to work with the resident and his sister on appropriate discharge back to the community Social Services has been re-educated on or before 7/5/12 on developing a care plan if there is a potential for discharge Random audits of resident records with potential for discharge will be completed by the Administrator monthly for 3 months to determine continued compliance. The Administrator shall report to the QA Committee monthly any variances in the data collected. The QA Committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance	

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F 514	Continued From page 42 During the Medication Pass observations on 6/1/12 at 7:50 AM and 1 PM, E13 administered R186's ordered medications (Janumet, Aspirin and Senna) but failed to document the administration of these medications. Findings were acknowledged by E13 and E3 (ADON #1) during interviews on 6/1/12. E13 stated that she administered medications but failed to sign them off. 5. There was a lack of documented evidence that discussions on community discharge planning for R170 took place. This information could not be found in social services notes. Resident was admitted to the facility on 1/20/12. Quarterly MDS dated 4/20/12 indicated diagnosis that included cerebral palsy, COPD, hearing loss, difficulty walking, and lack of coordination. Resident was coded as independent and without any short or long term memory problems. Social service assessment dated 4/20/12 indicated that resident lived alone and he made his own decisions and resident was to be discharged to home. A care plan did not exist for community discharge. In an interview with E28 (Social Service Director) on 6/11/12 at 11:01 AM, she stated the following: - "the plan was for him to go to community and his sister said if he could stay long term; she said she would like to see him go in community with some support; - She placed him in LTC status first and then because of R170's cerebral palsy, she looked at	F 514		

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F 514	Continued From page 43 that organization to see if they could assist - It looked like R170 was staying long term for a while and rehabilitation and he may be a good candidate for LTC too. R170 needed more services and had the care plan meeting and his sister is reluctant to have him in community by self; - The cerebral palsy organization thought would assist but he was not a candidate for support; - She then went to the money follow the person to see if he would quality and he did not (need to be 6 months at a facility to qualify for program). - Issue was who would be there to transition for extended care as he needed more support. Sister said he would not stay. - R170 was then enrolled in united community program and he just got approved for that. He got approved for united health care. And evaluated two weeks ago. - The reason she did not put a care plan for community discharge was because she did not know he would stay here; it was not confirmed and she was working behind the scenes and she did not want to have the care plan set up unless she knew for sure he would be going home. a care plan is for 90 days or less. - on June 8th, last week, she started talking to sister and she is not sure either; she evaluated R170 to be at home and she would have a big risk to discharge this man and she did not want to do a care plan. she just started looking into this again and has a note on 6/8/12 now working on the d/c - She had him coded as LTC and thought he would go home. She still has him as LTC in initial one. she did not put a care plan then and as of last week, she can put a care plan now. She had him as LTC right shortly after he came in.	F 514		

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F 514	Continued From page 44 - Not having a care plan was an oversight. she can put one forward as he will be working on discharge planning now. talked about it for a bit before...will put one today; nothing was happening for a while". Facility failed to document discussions on community discharge planning for R170. There was a lack of documented evidence this occurred.	F 514		

DELAWARE HEALTH AND SOCIAL SERVICES (DHSS)
Division of Long Term Care Residents Protection (DLTCRP)

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Hillside

DATE SURVEY COMPLETED: June 12, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An annual and complaint survey was conducted at this facility from May 31, 2012 and concluded on June 12, 2012. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility and hospital documentation as indicated. The facility census the first day of the survey was 99. The survey stage 2 sample totaled 59 residents with 5 closed records.	
3201.1.0	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.2	**Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** Cross refer to the CMS 2567-L survey report date completed 6/12/12, F164, F241, F253, F280, F309, F323, F329, F356, F371, F372, F431, F441, F463, F467 and F514.	Cross Reference F 356, F 241, F 280, F 309 F 329, F 372, F 431, F 463 F 514, F 164, F 253, F 323 F 441, F 467, F 371
3201.7.5	**Kitchen and Food Storage Areas.**	

Provider's Signature Jane K Ruark Title Administrator Date 6/28/12

NAME OF FACILITY: Hillside

DATE SURVEY COMPLETED: June 12, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Facilities shall comply with the 2011 Delaware Food Code. **This requirement was not met as evidenced by:** Based on the dietary observations during the survey, it was determined that the facility failed to comply with sections: 3-302.11, 3-302.12, 3-304.14, 3-501.16, 3-501-17, 3-602.11, 4-501.114, 4-601.11, 4-903.11, 5-402.11, 5-501.17, 5-501.115 and 6-501.11 of the State of Delaware Food Code. Findings include: **3-302.11 Packaged and Unpackaged Food - Separation, Packaging, and Segregation.** **(A) Food shall be protected from cross contamination by:** **(6) Protecting food containers that are received packaged together in a case or overwrap from cuts when the case or overwrap is opened;** **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed, 6/12/12, F371, example 1e. **3-302.12 Food Storage Containers, Identified with Common Name of Food.** **Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding FOOD or FOOD ingredients that are removed from their original packages for use in the FOOD**	

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	ESTABLISHMENT, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the FOOD. **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed, 6/12/12, F371, example 2. **3-304.14 Wiping Cloths, Use Limitation.** **(A) Cloths in-use for wiping FOOD spills from TABLEWARE and carry-out containers that occur as FOOD is being served shall be:** **(1) Maintained dry; and (2) Used for no other purpose.** **(B) Cloths in-use for wiping counters and other EQUIPMENT surfaces shall be:** **(1) Held between uses in a chemical sanitizer solution at a concentration specified under § 4-501.114; and** **(2) Laundered daily as specified under ¶ 4-802.11(D).** **(C) Cloths in-use for wiping surfaces in contact with raw animal FOODS shall be kept separate from cloths used for other purposes.** **(D) Dry wiping cloths and the chemical sanitizing solutions specified in Subparagraph (B)(1) of this section in which wet wiping cloths are held between uses shall be free of FOOD debris and visible soil.** **(E) Containers of chemical sanitizing solutions specified in Subparagraph (B)(1) of this section in which wet wiping cloths are held between uses shall be stored off the floor and used in**	

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	a manner that prevents contamination of FOOD, EQUIPMENT, UTENSILS, LINENS, SINGLE-SERVICE, or SINGLE-USE ARTICLES. **(F) SINGLE-USE disposable sanitizer wipes shall be used in accordance with EPA-approved manufacturer's label use instructions.** Cross refer to the CMS 2567-L survey report date completed, 6/12/12, F371, example 8. **3-501.16 Potentially Hazardous Food (Time/Temperature Control for Safety Food), Hot and Cold Holding.** **(A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under ¶ (B) and in ¶ (C) of this section, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) shall be maintained:** **(1) At 57oC (135oF) or above, except that roasts cooked to a temperature and for a time specified in ¶ 3-401.11(B) or reheated as specified in ¶ 3-403.11(E) may be held at a temperature of 54°C (130°F) or above; or** **(2) At 5°C (41°F) or less.** Cross refer to the CMS 2567-L survey report date completed, 6/12/12, F371, example 12. **3-501.17 Ready-to-Eat, Potentially Hazardous Food (Time/Temperature Control for Safety Food), Date Marking.** **(A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified**	

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	under § 3-502.12, and except as specified in ¶¶ (D) and (E) of this section, refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of 7 days. 86 (B) Except as specified in ¶¶ (D) - (F) of this section, refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in ¶ (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. (C) A refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) ingredient or a	

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	portion of a refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) that is subsequently combined with additional ingredients or portions of FOOD shall retain the date marking of the earliest-prepared or first prepared ingredient. (D) A date marking system that meets the criteria stated in ¶¶ (A) and (B) of this section may include: (2) Marking the date or day of preparation, with a procedure to discard the FOOD on or before the last date or day by which the FOOD must be consumed on the premises, sold, or discarded as specified under ¶ (A) of this section; (3) Marking the date or day the original container is opened in a FOOD ESTABLISHMENT, with a procedure to discard the FOOD on or before the last date or day by which the FOOD must be consumed on the premises, sold, or discarded as specified under ¶ (B) of this section; or 87 (4) Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the REGULATORY AUTHORITY upon request. (6) Shelf stable, dry fermented sausages, such as pepperoni and Genoa salami that are not labeled "Keep Refrigerated" as specified in 9 CFR 317 Labeling, marking devices, and containers, and which retain the original CASING on the product; and (7) Shelf stable salt-cured products such as prosciutto and Parma (ham) that are not labeled "Keep	

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	Refrigerated" as specified in 9 CFR 317 Labeling, marking devices, and containers. **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed, 6/12/12, F371, Example 1, 2, 3. **3-602.11 Food Labels.** **(A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers.** **(B) Label information shall include:** **(1) The common name of the FOOD, or absent a common name, an adequately descriptive identity statement;** **(2) If made from two or more ingredients, a list of ingredients in descending order of predominance by weight, including a declaration of artificial color or flavor and chemical preservatives, if contained in the FOOD;** **(4) The name and place of business of the manufacturer, packer, or distributor; and** **(5) The name of the FOOD source for each MAJOR FOOD ALLERGEN contained in the FOOD unless the FOOD source is already part of the common or usual name of the respective ingredient (Effective January 1, 2006).** **(6) Except as exempted in the Federal Food, Drug, and Cosmetic Act § 403(Q)(3) - (5), nutrition labeling as**	

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	specified in 21 CFR 101 - Food Labeling and 9 CFR 317 Subpart B Nutrition Labeling. **(C) Bulk FOOD that is available for CONSUMER self-dispensing shall be prominently labeled with the following information in plain view of the CONSUMER:** **(1) The manufacturer's or processor's label that was provided with the FOOD; or 97** **(2) A card, sign, or other method of notification that includes the information specified under Subparagraphs (B)(1), (2), and (5) of this section.** **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed, 6/12/12, F371, Example 1, 2, 3. **4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils.** **(C) NON-FOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.** **or** **4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles.** **(A) Except as specified in ¶ (D) of this section, cleaned EQUIPMENT and UTENSILS, laundered LINENS, and SINGLE-SERVICE and SINGLE-USE ARTICLES shall be stored:** **(1) In a clean, dry location;**	

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	(2) Where they are not exposed to splash, dust, or other contamination; and **(B) Clean EQUIPMENT and UTENSILS shall be stored as specified under ¶ (A) of this section and shall be stored:** **(2) Covered or inverted.** **(C) SINGLE-SERVICE and SINGLE-USE ARTICLES shall be stored as specified under ¶ (A) of this section and shall be kept in the original protective PACKAGE or stored by using other means that afford protection from contamination until used.** **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed, 6/12/12, F371, example 6. **4-701.10 Food-Contact Surfaces and Utensils.** **EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be SANITIZED.** **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed, 6/12/12, F371, example 13. **5-402.11 Backflow Prevention.** **(A) Except as specified in ¶¶ (B), (C), and (D) of this section, a direct connection may not exist between the SEWAGE system and a drain originating from EQUIPMENT in which**	

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	FOOD, portable EQUIPMENT, or UTENSILS are placed. **(B) Paragraph (A) of this section does not apply to floor drains that originate in refrigerated spaces that are constructed as an integral part of the building.** **(C) If allowed by LAW, a WAREWASHING machine may have a direct connection between its waste outlet and a floor drain when the machine is located within 1.5 m (5 feet) of a trapped floor drain and the machine outlet is connected to the inlet side of a properly vented floor drain trap.160** **(D) If allowed by LAW, a WAREWASHING or culinary sink may have a direct connection.** **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed, 6/12/12, F371, Example 4a and 4b. **5-501.17 Toilet Room Receptacle, Covered.** **A toilet room used by females shall be provided with a covered receptacle for sanitary napkins.** **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed, 6/12/12, F371, example 5. **5-501.115 Maintaining Refuse Areas and Enclosures.**	

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	A storage area and enclosure for REFUSE, recyclables, or returnables shall be maintained free of unnecessary items, as specified under § 6-501.114, and clean. **or** **6-501.114 Maintaining Premises, Unnecessary Items and Litter.** **The PREMISES shall be free of:** **(A) Items that are unnecessary to the operation or maintenance of the establishment such as EQUIPMENT that is nonfunctional or no longer used; and** **(B) Litter.** **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed, 6/12/12, F372. **6-501.11 Repairing.** **PHYSICAL FACILITIES shall be maintained in good repair.** **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed, 6/12/12, F371, Example 9, 10. **4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitization -Temperature, pH, Concentration, and Hardness.** **A chemical SANITIZER used in a**	

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	SANITIZING solution for a manual or mechanical operation at contact times specified under ¶ 4-703.11(C) shall meet the criteria specified under § 7-204.11. Sanitizers, Criteria, shall be used in accordance with the EPA registered label use instructions, and shall be used as follows: **(C) A quaternary ammonium compound solution shall:** **(1) Have a minimum temperature of 24°C (75°F),** **(2) Have a concentration as specified under § 7-204.11 and as indicated by the manufacturer's use directions included in the labeling, and** **(3) Be used only in water with 500 MG/L hardness or less or in water having a hardness no greater than specified by the EPA-registered label use instructions;** **(D) If another solution of a chemical specified under ¶¶ (A) -** **(C) of this section is used, the PERMIT HOLDER shall demonstrate to the REGULATORY AUTHORITY that the solution achieves SANITIZATION and the use of the solution shall be APPROVED; and** **7-204.11 Sanitizers, Criteria.** **Chemical SANITIZERS and other chemical antimicrobials applied to FOOD-CONTACT SURFACEs shall meet the requirements specified in 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface sanitizing solutions).** **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey	

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	report date completed, 6/12/12, F371, example 7.	